

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 File 274 11-7-60 279 1/13/61		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND		09583
9612				
Items 3, 8, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60 et				
1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsbrogh</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>17X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Stacy</u> Last <u>Baynard</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Sept. 22, 1959</u>	9. AGE (In years last birthday) <u>51</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland, Easton</u>
13. FATHER'S NAME <u>Paul Norman Baynard</u> <u>JAMES BAYNARD SR.</u>		14. MOTHER'S MAIDEN NAME <u>LAURA Mooney</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sama Mooney, Hillsbrogh Ind</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493x</u> <u>Focal</u> <u>interlobular pneumonia, right</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>upper lobe, predominately monoaclear,</u> lying cause last. (b) <u>with foci of necrosis.</u> (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>6:15 PM</u> and that death occurred on <u>6:15 PM</u> from the causes and on the date stated above.				
22a. SIGNATURE <u>E.C.H. Schmidt</u>		22b. ADDRESS <u>Easton, Maryland</u>		22c. PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/27/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sandtown, cem</u>	23d. LOCATION (City, town, or county) (State) <u>Hillsbrogh, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Deibel</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Knead</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>
DATE <u>AUG 29 '60</u>				

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1950

THE REPORT MADE BY THE BOARD OF HEALTH
ON THE STATE OF THE HEALTH OF THE PEOPLE
OF THE DISTRICT OF COLUMBIA
FOR THE YEAR 1950

1951



9613

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN Ib <i>25 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mr. Benson Bradford Berry</i>		4. DATE OF DEATH <i>August 3 1960</i>	
5. SEX <i>Male</i>	6. COLOR OF SKIN <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 11, 1874</i>
9. AGE (In years last birthday) <i>85</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Edwin J. Berry</i>		14. MOTHER'S MAIDEN NAME <i>Phyllis Warner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <i>214-18-4562</i>	
17. INFORMANT <i>Louis Berry</i>		Address <i>Easton Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i> DUE TO <i>Myocardial aneurysm</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary occlusion</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. C. H. Schmitt</i>		M.D. <i>2195 West 11th St. 3 Aug 60</i>	
PHYSICIAN'S NAME (Type) <i>E. C. H. Schmitt</i>		ADDRESS (Street, city or town, state) <i>Easton, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried Aug 5, 1960</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Easton Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marceline H. Neumann & Son</i>		ADDRESS <i>Easton, Md.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
DATE <i>AUG 8 '60</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1913

CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09585

1. PLACE OF DEATH a. COUNTY <u>TA/160</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - FEDERALSBURG</u> d. STREET ADDRESS <u>05X-2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>GERTRUDE</u> Last <u>Blockson</u>		4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 26, 1883</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>EMMA CANNON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Wm. B. Ricketts</u> Address <u>RFD - FEDERALSBURG, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Central thrombosis - c</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Al. hemiplegia</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>23 Aug</u> 19 <u>60</u> to <u>29 Aug</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>26 Aug</u> 19 <u>60</u> , and that death occurred at <u>4:55</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Thorston Harrison</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. ADDRESS <u>Canton, Maryland</u>	
22c. PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>		22d. ADDRESS <u>Canton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 2, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>CAROLINE COUNTY MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton & Son</u>		25a. REC'D BY REGISTRAR <u>SEP 6 '60</u>	
ADDRESS <u>FEDERALSBURG, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

11-553

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1917

11-553

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1872		New York City	
Cause of Death		Disease		Symptoms		Time of Death		Place of Death	
Heart Disease		Myocardial Infarction		Chest Pain, Shortness of Breath		Jan 15, 1917		New York City	
Occupation		Education		Marital Status		Religion		Signature of Physician	
Teacher		High School		Married		Catholic		[Signature]	
Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

11-553

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09586

9615

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN 1b <u>33 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>17X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Blake</u> Last <u>Boyce</u>				4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/14/1910</u>		9. AGE (In years lost birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>11/5/09</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry E. Blake</u>				14. MOTHER'S MAIDEN NAME <u>Hester Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>184-22-5779</u>		17. INFORMANT <u>Earl Boyce, Centreville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia cause</u> <u>790-1</u> DUE TO <u>undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) lost saw the deceased alive on _____ 19____, and that death occurred at <u>Easton, Md.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>E. C. H. Schmidt</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>29 Aug 60</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-3-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Bur.</u>		23d. LOCATION (City, town, or county) _____ (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Smith, Easton, Md.</u>				ADDRESS <u>Easton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 7 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

11/28

CERTIFICATE OF DEATH

11/28



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 8, 9 Film G271 9-15-60 et

CERTIFICATE OF DEATH

09587

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 616 GOLDSBORO ST	
3. NAME OF DECEASED (Type or print) BELLE First A-BREININGER Middle LAST AUG 25 1960		4. DATE OF DEATH	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 10, 1908
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (State or foreign country) NEBRASKA
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME FRED-W-ANTHONY	
14. MOTHER'S MAIDEN NAME CORA-L-PARKER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT MRS. BELL ANDREWS Address HORLOCK MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential hypertension, chronic			INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 19 60 , to 25 Aug , 19 60 , that I last saw the deceased alive on 25 Aug , 19 60 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Maurice Harrison M.D.		DATE SIGNED 26 Aug 60	
PHYSICIAN'S NAME (Type) THORSTON HARRISON		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF AUG. 29, 1960	22c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEM.	22d. LOCATION (City, town, or county) (State) ROTZTOWN PENN'A
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newman Address Easton Md.		24a. REC'D BY REGISTRAR DATE AUG 30 '60	24b. REGISTRAR'S SIGNATURE Charles L. Evans

10-253

CERTIFICATE OF DEATH

018



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wittman</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Wittman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Clifton</u> First <u>A.</u> Middle <u>Brooks</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/19/07</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oyster Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Brooks</u>		14. MOTHER'S MAIDEN NAME <u>MARY F. Makoney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-05-0231</u>	
17. INFORMANT Address <u>Mrs. Lathy Brooks Wittman, M.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> DUE TO <u>463X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PHLEBITIS OF LEG VEINS</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>P.M.</u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>63P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>EASTON, MD.</u> DATE SIGNED <u>8-16-60</u>			
ACTUAL SIGNATURE <u>Louis S. Welty</u> M.D.			
PHYSICIAN'S NAME (Type) <u>LOUIS S. WELTY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shenwood Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Shenwood Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sam S. Dashiell, Easton, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>AUG 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9617

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09589

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>05X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Robert</u> Last <u>Butler</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1883</u>
9. AGE (In years last birthday) <u>77</u> <u>yes</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Richard Butler</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. A. J. Fletcher</u> Address <u>Denton</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO <u> </u> (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 25, 1960</u> to <u>Aug. 25, 1960</u> that (I) (we) last saw the deceased alive on <u>Aug. 25, 1960</u> , and that death occurred at <u>7:50</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. C. Friesinger</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u>2000 Dorcas Street, Denton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug. 28, 1960</u>		23b. DATE THEREOF <u> </u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		23d. LOCATION (City, town, or county) <u>Denton</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Edgar Moore</u> ADDRESS <u>Denton, Md</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u>	
DATE <u>AUG 29 '60</u>			

00780

CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9618

09591

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Dor</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hurlock</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>Main 09X-2</i>	
3. NAME OF DECEASED (Type or print) <i>Orem</i> First <i>FRANCIS</i> Middle <i>CANNON</i> Last		4. DATE OF DEATH <i>Aug. 19</i> 1960	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/31/1884</i> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Rt</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Francis H. Cannon</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Bowdle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. O. J. Cannon</i>		Address <i>Hurlock</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous</i> DUE TO (b) <i>Renal cell carcinoma</i> DUE TO (c) <i>180X</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i> <i>3 yr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>April</i> 1960, to <i>Aug</i> 1960, that (I) (we) last saw the deceased alive on <i>8-18</i> 1960, and that death occurred at <i>11:30</i> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>H. R. TRAPNELL</i>		22b. DATE SIGNED <i>8-19-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>H. R. TRAPNELL</i>		22d. ADDRESS <i>Federalburg Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>8/22/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Washington</i>	23d. LOCATION (City, town, or county) (State) <i>Hurlock Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ruth S. Willoughby</i>		25a. REC'D BY REGISTRAR <i>Aug 22 '60</i>	
ADDRESS <i>East New Market</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

1918

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[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be a narrative or medical history.]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9644

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09592

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural St. Michaels</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wesley</u> Middle <u>Larsen</u> Last <u>Carmichael</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2, 1909</u>
9. AGE (In years lost birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTH PLACE (State or foreign country) <u>Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Col. Charles Larsen</u>		14. MOTHER'S MAIDEN NAME <u>Christina A. Peterson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Helton J. Carmichael</u> Address <u>St. Michaels, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial Pulmonary fibrosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that death occurred at _____ M. from the causes and on the date stated above.			
22a. SIGNATURE <u>E. C. H. Schmidt</u>		22b. DATE SIGNED <u>Aug 11 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Canton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 13</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Orange</u>		23d. LOCATION (City, town or county) (State) <u>Stearns, Connecticut</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Kraus</u> ADDRESS <u>Canton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 15 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

100283



CERTIFICATE OF DEATH

100283



TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>2224 40TH PL N.W. WASH. D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>47X-A</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Hardey Clarke</u>		4. DATE OF DEATH <u>August 20 1960</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 21, 1890</u> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INVESTMENT BROKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>WALNUT GROVE, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
3. FATHER'S NAME <u>THOMAS CLARKE</u>				14. MOTHER'S MAIDEN NAME <u>ELLA HARDY (Daughter)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>215-10-7025</u>		17. INFORMANT <u>JEAN CUSHING</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3hr.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF DEATH <u>9:15</u> p.m. 19 <u> </u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Louis Shultz</u>		M.D. <u>WIELT</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-20-60</u>	
EXAMINER'S NAME (Type) <u>WIELT</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL <u>XXXX</u>		22b. DATE THEREOF <u>8-24-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>BALTIMORE, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		ADDRESS <u>WASH. D.C.</u>		24a. REC'D BY REGISTRAR <u>AUG 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraw</u>	
JOSEPH GAWLER'S SONS, INC.		1756 PA. AVE. N.W.					

RECEIVED
JUL 24 1964



Report

Final

Memorial for

John Wiley Clarke - Graduate

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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9645

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09594

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sherwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>P.O. Box 3</u>		d. STREET ADDRESS <u>P.O. Box 3</u>	
3. NAME OF DECEASED (Type or print) First <u>ROSIE</u> Middle <u>E.</u> Last <u>Dennis</u>		4. DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>Annie Mason</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-04-1668</u>	
17. INFORMANT <u>Littleton Dennis, Sherwood, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>290.0</u> DUE TO <u>Pernicious anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 9, 1960</u> to <u>Aug 9, 1960</u> , that I last saw the deceased alive on <u>Aug 9, 1960</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>GUY M REESER</u> M.D.		ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>8/13/60</u>	
PHYSICIAN'S NAME (Type) <u>GUY M REESER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cmn</u>	22d. LOCATION (City, town, or county) (State) <u>Sherwood, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Deakins, Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 17 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09593

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hickman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>05 X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>MAY</u> Last <u>Drummond</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12, 1903</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Helsley</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Jordan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>123-45-6789</u>	
17. INFORMANT <u>Ruth Drummond Denton</u>		Address <u>Denton</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain abscess, left temporal</u> <u>342X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____ 19 _____, to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that death occurred at _____ 10:10 A. M. from the causes and on the date stated above.			
22a. SIGNATURE <u>E. C. H. Schmidt</u>		22b. DATE <u>Aug 22 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>Aug 25, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Concord</u>		23d. LOCATION (City, town, or county) <u>Concord Ind.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Moore & Son</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kline</u>	
24b. ADDRESS <u>Denton</u>		24c. DATE <u>AUG 29 '60</u>	

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STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1 23 Haddon St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Ola</u> Middle <u>Nevell</u> Last <u>Dyott</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1900</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>25</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emmett M. E. Collins</u>				14. MOTHER'S MAIDEN NAME <u>Amy Dean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>770-26-146</u>		INFORMANT <u>Emmett Lee Dyott</u>		Address <u>Easton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>561.5</u> DUE TO <u>Acute pericarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stagnulated pericarditis</u> (c) <u>Obesity</u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>7:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmitt</u>		M.D. <u>219 S. Washington St.</u>		DATE SIGNED <u>7 Aug 60</u>		ADDRESS (Street, city or town, state) <u>Easton, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmitt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Aug 9, 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Thomas</u>		ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

1898

CERTIFICATE OF DEATH

1898

STATE OF NEW YORK
COUNTY OF ALBANY

Attest
I, the undersigned, a Justice of the Peace for the County of Albany, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the said County of Albany.

Witness my hand and seal this 1st day of January, 1898.

JOHN J. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09597

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES First MARTIN Middle EMERSON Last		4. DATE OF DEATH August Month 21 Day 1960 Year	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 27, 1888
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TICKET AGENT		10b. KIND OF BUSINESS OR INDUSTRY THEATER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Wm L. EMERSON		14. MOTHER'S MAIDEN NAME MARY ANN DONLIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 440-32-9826	
17. INFORMANT MRS KATHERINE B. EMERSON, EASTON		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute gastric & intestinal obstruction dilatation 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) supra-pubic prostatic 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.			
22a. SIGNATURE E. C. H. Schmidt		22b. DATE 21 Aug 1960	
22c. PHYSICIAN'S NAME (Type) E. C. H. Schmidt		22d. ADDRESS Easton Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF Aug 24, 60	
23c. NAME OF CEMETERY OR CREMATORY Springfield		23d. LOCATION (City, town, or county) (State) Easton	
24. FUNERAL DIRECTOR'S SIGNATURE Robert		25a. REC'D BY REGISTRAR AUG 24 60	
25b. REGISTRAR'S SIGNATURE Robert S. Aramb			

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CERTIFICATE OF ADOPTION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9646
CERTIFICATE OF DEATH

09598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 45A Route 3</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> d. STREET ADDRESS <u>Box 45A Route 3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALBERTHA</u> Middle <u>LONG</u> Last <u>EVANS</u>				4. DATE OF DEATH Month <u>AUG.</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/25</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Robert Johnson</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA Ann Fester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Gene Evans, Easton, Md.</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> DUE TO <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8-7-1960</u> , to <u>8-7-1960</u> , that I last saw the deceased alive on <u>8-7-1960</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald F. Bartley</u> M.D.				ADDRESS (Street, city or town, state) <u>9 N. HANSON ST. EASTON MD</u>			
PHYSICIAN'S NAME (Type) <u>DONALD F. BARTLEY</u>				DATE SIGNED <u>8-9-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RICHARDS Cem</u>		22d. LOCATION (City, town, or county) (State) <u>EASTON Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James P. Danhill, Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>AUG 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	



Done



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9647

CERTIFICATE OF DEATH

09599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS (RURAL) 6 MO.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON 40	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RIO VISTA NURSING HOME		d. STREET ADDRESS 5, AURORA ST. 1	
3. NAME OF DECEASED (Type or print) AL VERDA First Middle Last GAREY		4. DATE OF DEATH AUGUST 17 1960 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 20, 1880
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICAL NURSE		10b. KIND OF BUSINESS OR INDUSTRY DELAWARE	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME CHARLES WARRINGTON		14. MOTHER'S MAIDEN NAME SARAH E COLLINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or date of service)		16. SOCIAL SECURITY NO. WARRINGTON-GAREY Address EASTON MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular DUE TO 7 up (c) Diabetes Mellitus DUE TO 10 up		INTERVAL BETWEEN ONSET AND DEATH 5 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 Feb , 19 60 to 17 Aug , 19 60 , that I last saw the deceased alive on 10 Aug , 19 60 , and that death occurred at 10:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Box 487, St. Michaels, Md DATE SIGNED 8-18-60			
ACTUAL SIGNATURE R. Lane Wraith M.D.		PHYSICIAN'S NAME (Type) R. Lane Wraith	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 18, 1960	
22c. NAME OF CEMETERY OR CREMATORY SPRING HILL CEM		22d. LOCATION (City, town, or county) (State) EASTON MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newman ADDRESS Easton Md.		24a. REC'D BY REGISTRAR DATE AUG 19 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1940

CERTIFICATE OF DEATH

1941

ORIGINAL

1940

1941

1942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9623

09600

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>32 da.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 EASTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1617 GOLDSBORO ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Foreman</u> Last <u>Golt</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 9, 1890</u>		9. AGE (In years last birthday) <u>70</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD F. FOREMAN</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE E. FRAMPTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. ORVILLE H. DYOTT, EASTON, MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>443</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic</u> DUE TO (c) <u>Cardio Vascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Renal Failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/27, 1960</u> to <u>8/18, 1960</u> , that (I) (we) last saw the deceased alive on <u>8/18, 1960</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>L. J. Eglsefer</u>				22b. DATE SIGNED <u>8/18/60</u>		22c. PHYSICIAN'S NAME (Type) <u>L. J. EGLSEDER</u>	
22d. ADDRESS <u>EASTON, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/20/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CMT.</u>		23d. LOCATION (City, town, or county) (State) <u>EASTON, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Conell</u>				25a. REC'D BY REGISTRAR <u>AUG 22 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	

10580

OFFICE OF THE SECRETARY OF THE ARMY

10580

10580

RECEIVED
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.
JAN 10 1910
10580

1

9624

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 20 hrs. 15 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.		d. STREET ADDRESS 05X-2	
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Harris		4. DATE OF DEATH Month Aug Day 2 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 24, 1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner		10b. KIND OF BUSINESS OR INDUSTRY farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES HARRIS		14. MOTHER'S MAIDEN NAME ELIZABETH ANN FLOWERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Miss Lewis Henry Denton, Ind. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.5 DUE TO Intestinal Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2195 Washington St. SE. 3rd Fl. 60 DATE SIGNED ACTUAL SIGNATURE E.C.H. Schmidt M.D. Easton, Maryland PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 5, 1960		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Denton, Ind.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Virgil Moore ADDRESS Easton, Ind.		24a. REC'D BY REGISTRAR DATE AUG 8 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1884

CERTIFICATE OF DEATH

1884

STATE OF NEW YORK

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. Some legible fragments include:]

... of the County of ... State of New York ...

... died on the ... day of ... 1884 ...

... at the residence of ...

... Cause of death ...

... Signed and sworn to before me this ... day of ... 1884 ...

... [Signature] ...



1
FOR STATE
HEALTH DEPT.

TO DEED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9648 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09602

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Talbot</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Newcomb</u>		c. LENGTH OF STAY in 1b <u>7 yrs.</u>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Newcomb</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oak Creek</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>5</u> Middle <u>Holland</u> Last			4. DATE OF DEATH Month <u>Aug</u> Day <u>27</u> Year <u>1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 26, 1953</u>		9. AGE (In years last birthday) <u>7</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Douglas Holland</u>		
14. MOTHER'S MAIDEN NAME <u>Louise Sedgwick</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>Mrs Douglas Holland, Newcomb, MD</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned in creek swimming</u>			
20c. TIME OF INJURY Month, Day, Year <u>8-27-60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Oak Creek</u>	20f. (City or town) <u>Newcomb Tal.</u>	(County) <u>MD</u>	(State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Louis Shetty</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-27-60</u>	
EXAMINER'S NAME (Type) <u>WELTY</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-30-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springhill Cemetery</u>	22d. LOCATION (City, town, or country) <u>Easton MD</u>	(State) <u>MD</u>
23. FUNERAL DIRECTOR <u>Hamilton Harrison, St. Michaels MD</u>			24a. REC'D BY REGISTRAR DATE <u>SEP 2 '60</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

MEDICAL CERTIFICATION

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5th Ave. New York 17, N.Y.



30-18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK

CITY OF NEW YORK

DEPARTMENT OF HEALTH

DEATH CERTIFICATE

NO. 1000

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Previous Illnesses

Medical History

Family History

Signature of Physician

Signature of Medical Examiner

Signature of Coroner

Signature of Registrar

Signature of Clerk

Signature of Nurse

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09603

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> 9625 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>35 min</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u> d. STREET ADDRESS <u>05X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Luther</u> First <u>Herman</u> Middle <u>Lee</u> Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct 30, 1910</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years lost birthday) <u>49</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				4. DATE OF DEATH <u>August 19</u> 19 <u>60</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u> 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Jacob F. Lee</u> 14. MOTHER'S MAIDEN NAME <u>Elmira Cleverger</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Mrs. Luther Lee</u> Address <u>Preston, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> 19 <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>19 Aug</u> 19 <u>60</u> to <u>19 Aug</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>19 Aug</u> 19 <u>60</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Thorston Harrison</u> 22c. PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>				22b. DATE SIGNED <u>19 Aug 60</u> 22d. ADDRESS <u>Carle, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Aug 23, 1960</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Denton</u> 23d. LOCATION (City, town, or county) <u>Denton, Md.</u> (State) <u> </u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Moore</u> ADDRESS <u>Denton, Md.</u> 25a. REC'D BY REGISTRAR DATE <u>AUG 29 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2004

CERTIFICATE OF DEATH

5852



[Faint, mostly illegible handwritten text, likely a death certificate form with fields for name, date, and cause of death.]

9626

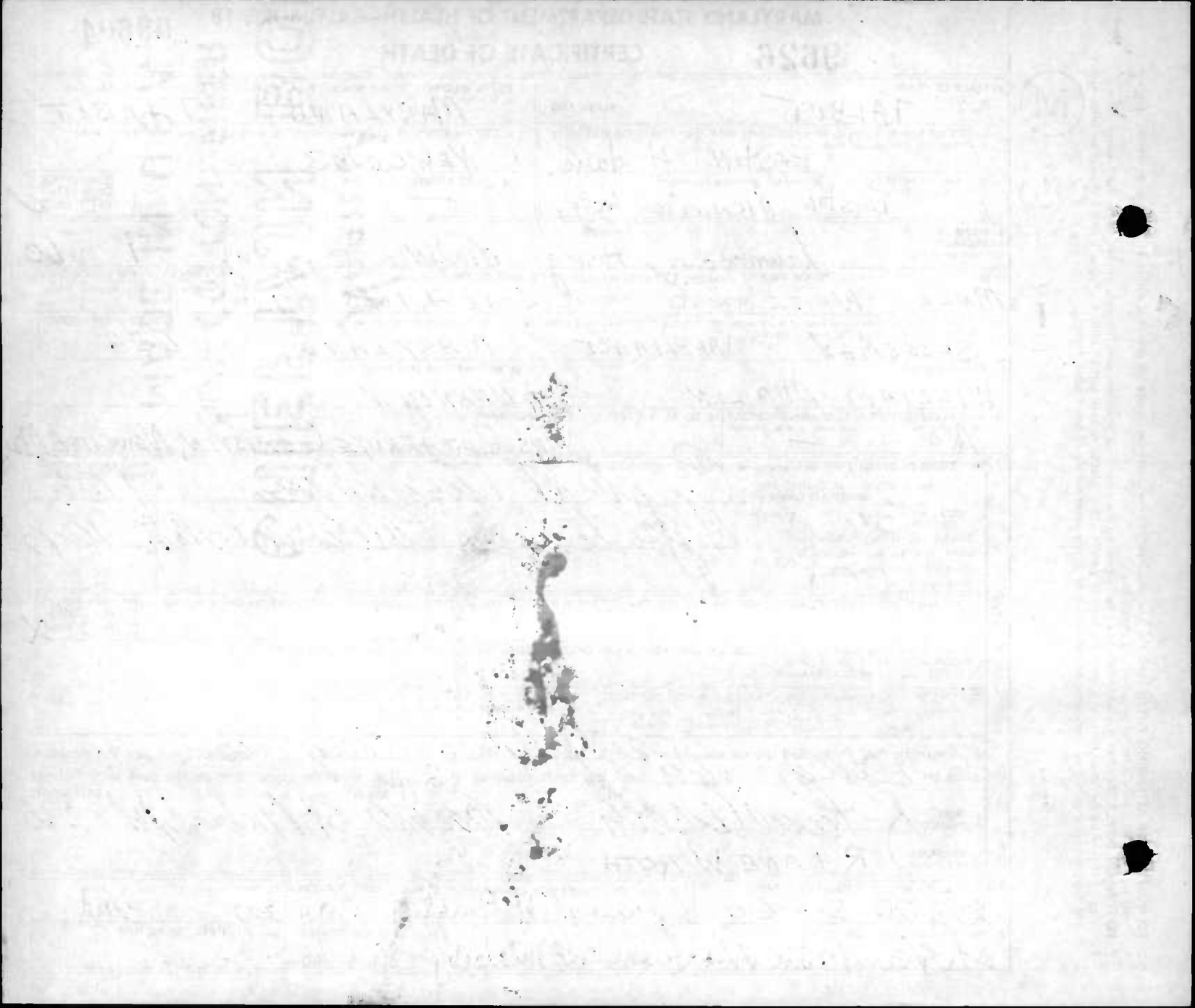
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lawrence Middle Henry Last Malin				4. DATE OF DEATH Month Aug Day 1 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4, 1885	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY APPLIANCE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM MALIN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		INFORMANT Address MRS CATHERINE CORISTIN, NEWCOMB MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4443 X Cerebral Thrombosis DUE TO (b) Hypertensive Cardiovascular; 1044 DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 1 wk.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 July, 1960 , to 10 Aug, 1960 , that I last saw the deceased alive on 1 Aug, 1960 , and that death occurred at 2 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE K. Russell Chaff				DATE SIGNED 8-2-60			
PHYSICIAN'S NAME (Type) R. LANE W. ROTH				ADDRESS (Street, city or town, state) Box 487, St. Michaels, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-4-60		22c. NAME OF CEMETERY OR CREMATORY Springhill Cemetery		22d. LOCATION (City, town, or county) (State) Easton Md	
23. FUNERAL DIRECTOR'S SIGNATURE L. A. Hambleton Harrison				24a. REC'D BY REGISTRAR St. Michaels		24b. REGISTRAR'S SIGNATURE —	
				DATE AUG 5 '60			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



09605

1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels,	
d. NAME OF HOSPITAL (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jesse Norman Marshall		4. DATE OF DEATH Month 8 - Day 20 Year 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH August 6, 1885	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 8 Days 20 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marshall's Express		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jesse Marshall		14. MOTHER'S MAIDEN NAME Celia Willis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ukn.	
17. INFORMANT Norman D. Marshall		Address St. Michaels, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Dis. (c) 6-7 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schist. Enteritis etc. with? viral.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 8 Day 17 Year 1960 Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-17 1960 to 8-20 1960 , that (I) (we) last saw the deceased alive on 8-20 1960 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE R. Lane Wroth		22b. DATE SIGNED 8-20-60	
22c. PHYSICIAN'S NAME (Type) R. Lane Wroth		22d. ADDRESS St. Michaels, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/22/60	
23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		23d. LOCATION (City, town, or county) (State) St. Michaels, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Hamilton Conell		25a. REC'D BY REGISTRAR DATE AUG 23 '60	
ADDRESS Easton, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
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9628

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09607

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>	
4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1960</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Charlotte</u> Last <u>Newnam</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 22 1880</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>NEAVITT, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John NIBLETT</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH PARKS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mc Coy Newnam, St Michael</u>		Address <u>St Michael</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>W 3 wks.</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>3:22</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED <u>8/30/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 31, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Neavitt Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Neavitt Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hampton Harrison, St. Michael, Md.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. House</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>SEP 2 '60</u>	

1880

STATE OF TEXAS
COUNTY OF DALLAS

1880

John Niblett

MD

Easton

Tricot

Griffin

John Niblett
 Housewife
 Female white
 born 22 1840
 married 1862
 first child 1865
 second child 1868
 third child 1871
 fourth child 1874
 fifth child 1877
 sixth child 1880

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1880

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09606

9629

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION THE MEMORIAL Hospital				d. STREET ADDRESS Rt # 3 Box 303			
3. NAME OF DECEASED (Type or print) First TIMOTHY Middle - Last NEWMAN				4. DATE OF DEATH Month August Day 12 Year 1960			
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH OCT 7, 1910		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY LANDSCAPING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HEBREW NEWMAN				14. MOTHER'S MAIDEN NAME MARY ELLEN HAWKINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-05-4521		17. INFORMANT Address Mrs. ELIZA NEWMAN CENTREVILLE, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, right DUE TO SINUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephritis, bilateral DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
22a. SIGNATURE E. C. Harrison				M.D. ATTENDING PHYS. Robert J. Harrison		22b. DATE SIGNED Aug 12 1960	
22c. PHYSICIAN'S NAME (Type) E. C. Harrison				22d. ADDRESS Easton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Aug. 14, 1960		23c. NAME OF CEMETERY OR CREMATORY EARLE'S CHAPEL CEMETERY		23d. LOCATION (City, town, or county) (State) RURAL CENTREVILLE, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James H. Butler				ADDRESS of Butler Bros., Centerville, Md.		25a. REC'D BY REGISTRAR DATE AUG 16 '60	
				25b. REGISTRAR'S SIGNATURE Carlton S. Kinney			

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CERTIFICATE OF DEATH

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of 11.4
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON RURAL 3mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON RURAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Wesley Paluck</u>		4. DATE OF DEATH <u>August 14</u> 1960	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 11, 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOSIERY MACHINIST</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>	
13. BIRTHPLACE (State or foreign country) <u>Poland</u>		14. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
15. FATHER'S NAME <u>Anthony Paluszkievicz</u>		16. MOTHER'S MAIDEN NAME <u>(Unknown) Bernia Poland.</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give unit or date of service) <u>Yes U.S. I</u>		18. SOCIAL SECURITY NO. <u>217-07-18592</u>	
19. INFORMANT <u>Mrs. James Price</u>		Address <u>Easton Md.</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF DEATH Month, Day, Year <u>8-14</u> 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Loris Delaney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>INELT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or DISPOSAL <u>Burial</u>		22b. DATE THEREOF <u>Aug. 16, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cem.</u>		22d. LOCATION (City, town, or county) <u>Easton Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice C. Newman & Son</u>		ADDRESS <u>Easton Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Evans</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE OF TEXAS,
COUNTY OF DALLAS.

2002-03-01

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09610

9651

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>2 1/2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton RFD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D.</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Antonia Sampson Jr</u>				4. DATE OF DEATH Month Day Year <u>8 23 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/11/60</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>5</u>		IF UNDER 24 HRS. <u>5</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John A. Sampson sr</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Monroe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Ruth Sampson, Easton, Md</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTERSTITIAL PNEUMONIA</u> <u>525X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>P.M.</u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I lost saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>EASTON, MD.</u> DATE SIGNED <u>8-25-60</u> ACTUAL SIGNATURE <u>Louis S. Welty</u> M.D. PHYSICIAN'S NAME (Type) <u>LOUIS S. WELTY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/25/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mathis town em</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, R.F.D. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Smith, Easton, Ind.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Heard</u>	

VS A15 (4)
15M 9/55

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CERTIFICATE OF DEATH

3833



NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
AGE		SEX	
MARRIED		OCCUPATION	
EDUCATION		RELIGION	
MILITARY SERVICE		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
DATE OF BURIAL		CITY	
COUNTY		STATE	
SIGNATURE OF REGISTRAR		DATE	

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
AGE		SEX	
MARRIED		OCCUPATION	
EDUCATION		RELIGION	
MILITARY SERVICE		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
DATE OF BURIAL		CITY	
COUNTY		STATE	
SIGNATURE OF REGISTRAR		DATE	

may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9630

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09611

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 12 hr. 25 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				d. STREET ADDRESS None OSX-2			
3. NAME OF DECEASED (Type or print) Elfriede First 7. Middle Schneider Last				4. DATE OF DEATH Aug 24 19 60 Month 24 Day 19 Year 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-31-1891	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 24 Hours 19 Min.		IF UNDER 24 HRS. Months 69 Days 24 Hours 19 Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) France	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME No Record			
14. MOTHER'S MAIDEN NAME No Record				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Joseph Schneider Denton, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Arteriosclerotic Coronary Dis DUE TO (c) Diabetes mellitus							INTERVAL BETWEEN ONSET AND DEATH 24 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/23/1960 to 8/24/1960 , that (I) (we) last saw the deceased alive on 8/23/1960 , and that death occurred on 8/24 A.M. from the causes and on the date stated above.							
22a. SIGNATURE P. Evans Cox				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) P. Evans Cox M.D. Earle Ave. Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-27-60		23c. NAME OF CEMETERY OR CREMATORY Denton		23d. LOCATION (City, town, or county) (State) Denton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaie ADDRESS Greensboro, Md.				25a. REC'D BY REGISTRAR AUG 29 '60		25b. REGISTRAR'S SIGNATURE C. L. H. H.	

09311

CERTIFICATE OF DEATH

98701



Caroline

Harvard

Georgetown

John

1

1-11-1891

Female White

T.S.A.

France

Home

Housewife

No Record

No Record

Joseph Schmitt, Lemmon, Maryland

Home

No

1891



John Schmitt, Lemmon, Maryland

1891

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and in any event, within 72 hours after death. Pages 1 and 2 should be filled in by the funeral director, and in any event, within 72 hours after death. Pages 1 and 2 should be filled in by the funeral director, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9631

09612

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>25 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WITTMAN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. STREET ADDRESS <u>1 -</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Emil Dorrell Schomborg</u>				4. DATE OF DEATH Month Day Year <u>August 17 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 26, 1915</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POSTMASTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EMIL R. SCHOMBORG</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE DORRELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>214-01-4368</u>		17. INFORMANT Address <u>MRS. E. DORRELL SCHOMBORG, WITTMAN, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>atherosclerotic occlusive coronary artery d-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u> <u>24 hrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-15-60</u> to <u>8-17-60</u> , that (I) (we) last saw the deceased alive on <u>8-17-60</u> and that death occurred <u>12:05</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>8-17-60</u>		22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
22d. ADDRESS <u>[Signature]</u>				22e. ATTENDING PHYS. <u>X</u>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG. 19, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>TILGHMAN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>TILGHMAN, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 19 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

1891

1891

1
Name of Deceased
Age
Sex
Color
Date of Birth
Place of Birth
Date of Death
Place of Death
Cause of Death
Signature of Physician
Signature of Registrar
Date of Registration

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9632

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09613

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Queenstown</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS <i>17X-2</i>			
3. NAME OF DECEASED (Type or print) <i>John</i> First <i>LeCompte</i> Middle <i>Seney</i> Last				4. DATE OF DEATH <i>August 20 1960</i> Month Day Year			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 25 1907</i>		9. AGE (In years last birthday) <i>53</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Merchant</i>		11. BIRTHPLACE (State or foreign country) <i>Queen Anne's Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel W Seney</i>				14. MOTHER'S MAIDEN NAME <i>Fannie Kimble</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>179-07-0054</i>		17. INFORMANT <i>Mrs Alice W Seney</i> Address <i>Queenstown Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary atherosclerotic heart disease</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocardial infarction</i> DUE TO (c) <i>Cardiac failure</i>						INTERVAL BETWEEN ONSET AND DEATH (?) 3 hrs 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1957</i> to <i>20 Aug 1960</i> , that (I) (we) last saw the deceased alive on <i>20 Aug 1960</i> , and that death occurred at <i>9 P.M.</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Thurston Harrison</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>20 Aug 60</i>	
22c. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>				22d. ADDRESS <i>Easton, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug 23-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Church Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Church Hill Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. L. Brown & Son</i>				ADDRESS <i>Baltimore Md</i>		25a. REC'D BY REGISTRAR <i>AUG 25 '60</i>	
				25b. REGISTRAR'S SIGNATURE <i>Carthur S. Frank</i>			

9633

CERTIFICATE OF DEATH

09614
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Talb.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>9 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		40	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS <i>224 Wye Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Hilda</i> Middle <i>K.</i> Last <i>Shearer</i>				4. DATE OF DEATH Month <i>August</i> Day <i>9</i> Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/9/1895</i>	9. AGE (In years last birthday) <i>64</i> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph J. Kline</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Balser</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Morton L. Shearer - Same</i>		INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>153. Acute Gastro-intestinal hemorrhage</i> DUE TO (b) <i>Carcinoma of the colon</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>53</i> , to <i>9 Aug</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>9 Aug</i> , 19 <i>60</i> , and that death occurred at <i>3:45 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Easton, Maryland 9 Aug 60</i>							
ACTUAL SIGNATURE <i>Thurston Harrison</i>		M.D. <i>Easton, Maryland 9 Aug 60</i>					
PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/11/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Bellevue Friendship</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Harrison & Sons, Inc. 6010 Reisterstown Rd.</i>				24a. REC'D BY REGISTRAR <i>AUG 12 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10074

ENTIRE DATE OF DEATH

1883

10

1

X

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS 05X2	
3. NAME OF DECEASED (Type or print) First Florence Middle Smith Last Smith		4. DATE OF DEATH Month Aug Day 2 Year 1960	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 31, 1885
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Annie Sampson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Freddie Dargatzis 718 Mary St. Chester, Pa	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 31, 1960 to August 2, 1960 that I lost saw the deceased alive on August 1, 1960 and that death occurred at 5 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gottlieb C. Friesinger M.D.		ADDRESS (Street, city or town, state) 202 Pine Street, Easton, Maryland	
PHYSICIAN'S NAME (Type) Gottlieb C. Friesinger		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Aug. 5, 1960	Spring Grove	Denton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Virgil Woodson		24a. REC'D BY REGISTRAR DATE AUG 15 '60	
ADDRESS Denton		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2033

(M)

[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. There are several circular stamps and handwritten notations throughout the document.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09616

9635

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>35 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Hubert</u> Last <u>Suitt</u>				4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 22, 1914</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucking</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Hubert Suitt</u>				14. MOTHER'S MAIDEN NAME <u>Mannie Cash</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>Mrs. Louise H. Suitt, Preston, Maryland</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>ventricular fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertical infarction</u> (c) <u>Coronary thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>23 Aug 1960</u> to <u>23 Aug 1960</u> , that (I) (we) last saw the deceased alive on <u>23 Aug 1960</u> , and that death occurred at <u>5:30 PM</u> from the cause and on the date stated above.							
22a. SIGNATURE <u>Thurston Harrison</u>				22b. DATE SIGNED <u>23 Aug 60</u>			
22c. PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>				22d. ADDRESS <u>Carlton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8/26/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery Easton, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thurston Harrison</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Hanks</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	
25c. ADDRESS <u>Thurston Harrison, Easton, Md</u>				25d. DATE <u>AUG 29 '60</u>			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9636
CERTIFICATE OF DEATH

09617

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN lb 6 3/4 hrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION THE MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton d. STREET ADDRESS ? e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle GIRL Last WEBB		4. DATE OF DEATH Month 8 Day 6 Year 1960	
5. SEX F	6. COLOR OR RACE wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/6/60
9. AGE (In years last birthday) yrs. 6		10. IF UNDER 1 YEAR Months 6 Days 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RUFUS WEBB		14. MOTHER'S MAIDEN NAME BETTY JANE PURCELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Rufus Webb Denton, Ind.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Anoxemia (c) Asphyxia INTERVAL BETWEEN ONSET AND DEATH 1 hr 70z		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/6 , 19 60 , to 8/6 , 19 60 that I last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Talbot, Easton, Md. DATE SIGNED 8/9/60			
ACTUAL SIGNATURE E. N. Hardy		M.D. Talbot, Easton, Md.	
PHYSICIAN'S NAME (Type) ERVING D. HARDY M.D.		Same as above	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 8, 1960	
22c. NAME OF CEMETERY OR CREMATORY Laurel		22d. LOCATION (City, town, or county) (State) Laurel Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE J. V. Moore & Son		ADDRESS Denton, Md.	
24a. REC'D BY REGISTRAR AUG 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

208030 3XV0

(M)

1. Name of deceased: JOHN J. JONES
2. Sex: Male
3. Age: 45
4. Date of birth: 1910
5. Place of birth: NEW YORK
6. Date of death: 1955
7. Place of death: HOME
8. Cause of death: HEART DISEASE
9. Manner of death: NATURAL
10. Signature of physician: J. J. JONES
11. Signature of registrar: J. J. JONES
12. Date of registration: 1955

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
9637
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09618

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton The 30 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>09X-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Bradley Whiteley</u>		4. DATE OF DEATH Month Day Year <u>August 11 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 1, 1906</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Vienna, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Webb Bradley</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Bradley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-18-5068</u>	
17. INFORMANT <u>Walter O. Whiteley, Williamsburg, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Cerebral fracture</u> DUE TO <u>Hypertensive C-V disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 wks.</u> <u>(?)</u> <u>2 wks.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11 Aug 1960</u> to <u>11 Aug 1960</u> , that (I) (we) last saw the deceased alive on <u>11 Aug 1960</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thorston Harrison</u>		22b. DATE SIGNED <u>11 Aug 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>		22d. ADDRESS <u>Crofton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>AUG. 14, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hurlock, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton & Son</u>		25a. REC'D BY REGISTRAR <u>Federalburg, Maryland</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frazier</u>		DATE <u>AUG 16 '60</u>	



MASSACHUSETTS
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

3037

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09619

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Duval</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Williams</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>CO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1914</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>6</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral hypotension</u> DUE TO (c) <u>(?)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>18 Aug 1960</u> to <u>27 Aug 1960</u> , that (I) (we) last saw the deceased alive on <u>26 Aug 1960</u> , and that death occurred at <u>4 A.M.</u> from the cause and on the date stated above.			
22a. SIGNATURE <u>Thurston Harrison</u>		22b. DATE SIGNED <u>28 Aug 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR THURSTON HARRISON</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/3/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Int. Olive Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Jacksonville, Ind.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell</u>		25a. REC'D BY REGISTRAR <u>SEP 7 '60</u>	
ADDRESS <u>Easton, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09620

9639

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <i>Easton</i> c. LENGTH OF STAY IN 1b <i>13 days</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i> c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <i>Easton</i> d. STREET ADDRESS <i>1 RTD</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ethel</i> Middle <i>Williams</i> Last <i>Williams</i>				4. DATE OF DEATH Month <i>August</i> Day <i>17</i> Year <i>1960</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/20/90</i>		9. AGE (In years last birthday) <i>70</i> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>unknown</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Raymond Williams, Easton, Md.</i> Address _____					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Lymphatic Leukemia</i> DUE TO <i>20460</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pneumonia</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1957</i> to <i>8/17, 1960</i> , that (I) (we) last saw the deceased alive on <i>8/17, 1960</i> , and that death occurred at <i>6:10 PM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>L. J. Eglseder</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>8/17/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>L. J. EGLSEDER</i>				22d. ADDRESS <i>Easton Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/24/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Williamsburg Cem</i>		23d. LOCATION (City, town, or county) <i>Easton RT 2, Md.</i> (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Daskill</i> ADDRESS <i>Easton Md</i>				25a. REC'D BY REGISTRAR <i>AUG 29 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneiss</i>			

1938

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
STATE OF NEW YORK

1938

Full Name of Deceased

Date of Death

Place of Death

Age at Death

Sex

Color

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of Town Clerk

Signature of Village Clerk

Signature of Ward Clerk

Signature of Precinct Clerk

Signature of Assembly District Clerk

Signature of State Senator

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

9640

CERTIFICATE OF DEATH

45621
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN lb 52 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle HARRISON Last Willis		4. DATE OF DEATH Month August Day 2 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 8 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Fertilizer	
11. BIRTH PLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James H. Willis		14. MOTHER'S MARRIED NAME Marietta H. Parsones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 212-20-120	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Psychonephrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Carcinoma of prostate (b) Psychonephrosis (c) Carcinoma of prostate		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. C. H. Schmidt M.D.		DATE SIGNED 2195 Washington St. Aug 10	
PHYSICIAN'S NAME (Type) Easton, Maryland		22. LOCATION (City, town, or county) (State) Easton Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 4, 1960	
22c. NAME OF CEMETERY OR CREMATORY Easton Cem.		22d. LOCATION (City, town, or county) (State) Easton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newman & Son ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE AUG 8 '60	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

STATE OF TEXAS
COUNTY OF DALLAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 12 Film G269 8-19-60 et
CERTIFICATE OF DEATH

09622
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>6 da</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Ridgely</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK</u> First Middle Last		4. DATE OF DEATH <u>Aug 10 1960</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1882</u> yrs. Months Days Hours Min.
9. AGE (In years last birthday) <u>78</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Spruce Wm. DeFord, Jr. Ridgely, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A-H-D</u> DUE TO (c) <u>?</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/4/60</u> , 19 <u>60</u> , to <u>8/10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/10/60</u> , 19 <u>60</u> , and that death occurred at <u>8:50 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>EASTON, M.D.</u> DATE SIGNED <u>8/14/60</u> ACTUAL SIGNATURE <u>P. E. Cox</u> M.D. PHYSICIAN'S NAME (Type) <u>P. E. Cox</u> <u>EASTON, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 12, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Haley Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mont Sen</u> ADDRESS <u>Denton, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 15 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

OP

111083

CERTIFICATE OF DEATH

111083

(M)

[Faint, mostly illegible text from a death certificate form, including fields for name, age, sex, date of death, and cause of death.]

(1)

